PRINTED: 12/05/2012 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION G	COMPLET	
		175245	B. WIN	IG		12/0	5/2012
	ROVIDER OR SUPPLIER	RDSVILLE	•	7	REET ADDRESS, CITY, STATE, ZIP CODE 151 BLAKE ST. EDWARDSVILLE, KS 66111		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	EFIX (EACH CORRECTIVE ACTION		LD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	3	F	000			
F 253 SS=E	Health Resurvey and #KS60924 and #KS6 483.15(h)(2) HOUSE MAINTENANCE SEF The facility must provide maintenance services sanitary, orderly, and This REQUIREMENT by: The facility reported divided on four separ observation, and interprovide services necessarily.	KEEPING & RVICES ride housekeeping and s necessary to maintain a	F	253			
	resident living areas f survey. Findings included:	for 2 of 4 days on site of the					
	- On 11/26/12 at 2:14 a room on the A-hall finish, in the bathroor	4 P.M. observation revealed unit with chipped ceiling m, screws sticking out from ling surface at the base of or.					
	a room on the A-hall	A.M. observation revealed unit with missing floor tile ped and a peeling surface at sink mirror.					
	room on the A hall ur the bathroom sink an	P.M. observation revealed a nit with a corroded faucet in d the sink was chipped and					
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	 ` ′			
	175245	B. WING		12/05/2012	
	RDSVILLE	S	STREET ADDRESS, CITY, STATE, ZIP CODE 751 BLAKE ST. EDWARDSVILLE, KS 66111		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		
with rust stains. On 11/26/12 at 12:32 sink in a residents root the water would not to water in the bathroom. On 11/26/12 at 3:20 Froom on the D hall unthe sink. The facility policies re Maintenance/Housek housekeeping and all maintenance repairs to acknowledged the facin disrepair and said treplacing all the sinks throughout the buildin percent completed. The facility failed to mand homelike environ these areas. 483.20(b)(1) COMPR ASSESSMENTS The facility must concar comprehensive, accordingly accordingly. A facility must make a assessment of a residue.	P.M. observation revealed a om on the A-hall unit where urn off and there was no hot in. P.M. observation revealed a ait with water dripping under agarding eeping directed staff to report any needed to their supervisor. P.M. maintenance staff Z cility sinks and mirrors where they were in the process of an intrors and fixturing and this was about 65 maintain a clean, comfortable ment for the residents. in EHENSIVE duct initially and periodically curate, standardized ment of each resident's a comprehensive dent's needs, using the		53		
	, , ,				
	SUMMARY ST. (EACH DEFICIENCY REGULATORY OR IN TREGULATORY OR IN TR	OVIDER OR SUPPLIER LIVINGCENTER - EDWARDSVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 with rust stains. On 11/26/12 at 12:32 P.M. observation revealed a sink in a residents room on the A-hall unit where the water would not turn off and there was no hot water in the bathroom. On 11/26/12 at 3:20 P.M. observation revealed a room on the D hall unit with water dripping under the sink. The facility policies regarding Maintenance/Housekeeping directed housekeeping and all staff to report any needed maintenance repairs to their supervisor. On 11/29/12 at 1:20 P.M. maintenance staff Z acknowledged the facility sinks and mirrors where in disrepair and said they were in the process of replacing all the sinks, mirrors and fixturing throughout the building and this was about 65 percent completed. The facility failed to maintain a clean, comfortable and homelike environment for the residents. in these areas. 483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's	OVIDER OR SUPPLIER LIVINGCENTER - EDWARDSVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 with rust stains. On 11/26/12 at 12:32 P.M. observation revealed a sink in a residents room on the A-hall unit where the water would not turn off and there was no hot water in the bathroom. On 11/26/12 at 3:20 P.M. observation revealed a room on the D hall unit with water dripping under the sink. The facility policies regarding Maintenance/Housekeeping directed housekeeping and all staff to report any needed maintenance repairs to their supervisor. On 11/29/12 at 1:20 P.M. maintenance staff Z acknowledged the facility sinks and mirrors where in disrepair and said they were in the process of replacing all the sinks, mirrors and fixturing throughout the building and this was about 65 percent completed. The facility failed to maintain a clean, comfortable and homelike environment for the residents. in these areas. 483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified	OVIDER OR SUPPLIER LIVINGCENTER - EDWARDSVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 with rust stains. On 11/26/12 at 12:32 P.M. observation revealed a sink in a residents room on the A-hall unit where the water would not turn off and there was no hot water in the bathroom. On 11/26/12 at 3:20 P.M. observation revealed a room on the D hall unit with water dripping under the sink. The facility policies regarding Maintenance/Housekeeping directed housekeeping and all staff to report any needed maintenance repairs to their supervisor. On 11/29/12 at 1:20 P.M. maintenance staff Z acknowledged the facility sinks and mirrors where in disrepair and said they were in the process of replacing all the sinks, mirrors and fixturing throughout the building and this was about 65 percent completed. The facility failed to maintain a clean, comfortable and homelike environment for the residents. In these areas. 483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment of a resident's needs, using the resident assessment instrument (RAI) specified	OVIDER OR SUPPLIER INTINGENTER - EDWARDSVILLE SUMMARY STATEMENT OF DEPICIENCIES GEACH DEPICIENCY MIST BE PRECEDED BY FULL. RESULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 with rust stains. On 11/26/12 at 12:32 P.M. observation revealed a sink in a residents room on the A-hall unit where the water would not turn off and there was no hot water in the bathroom. On 11/26/12 at 3:20 P.M. observation revealed a room on the D hall unit with water dripping under the sink. The facility policies regarding Maintenance/Housekeeping directed housekeeping and all staff to report any needed maintenance repairs to their supervisor. On 11/29/12 at 1:20 P.M. maintenance staff Z acknowledged the facility sinks and mirrors where in disrepair and said they were in the process of replacing all the sinks, mirrors and fixturing throughout the building and this was about 65 percent completed. The facility failed to maintain a clean, comfortable and homelike environment for the residents. In these areas. 48.3.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment in strument (RAI) specified

	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175245	B. WIN	G		12/05/2012	
	OVIDER OR SUPPLIER	RDSVILLE		7	EET ADDRESS, CITY, STATE, ZIP CODE 51 BLAKE ST. DWARDSVILLE, KS 66111		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		_D BE	(X5) COMPLETION DATE
F 272	Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior p Psychosocial well-bei Physical functioning a Continence; Disease diagnosis an Dental and nutritional Skin conditions; Activity pursuit; Medications; Special treatments ar Discharge potential; Documentation of sur the additional assess areas triggered by the Data Set (MDS); and	atterns; ng; and structural problems; d health conditions; status;	F	272			
	by: The facility reported and the sample was 2 record review, and state to thoroughly complete.	is not met as evidenced a census of 92 residents 21. Based on observation, aff interview the facility failed the care area assessments cations for 2 of 10 reviewed					

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175245	B. WIN	G		12/0	5/2012
	ROVIDER OR SUPPLIER	RDSVILLE		751	ET ADDRESS, CITY, STATE, ZIP CODE BLAKE ST. WARDSVILLE, KS 66111		<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 272	Findings include: Resident #64's qual Assessment (MDS) of the resident with a Br Status score of 15, which was alert and oriente. The 2-11-12 Psychod Assessment (CAA) stresident received a reguard, covered cups, times to maintain his/ The CAA documente feed his/herself, requassistance with all act was frequently incont psychotropic medicat at risk for falls, physic changes, and injury the resident's symptothe resident's use of the 8-3-12 care plan with a potential for psychotropic medicat at risk for falls, physic changes, and injury the resident's use of the 8-3-12 care plan with a potential for psychotropic medicat of the resident's use of the granoia, delusions, to the diagnosis of somental condition that contact with reality (pproblems) and laid or furniture, and crawled was psychotic. Interverser the resident to the Committee, redirect the encourage the resident resident resident resident resident to the committee, redirect the encourage the resident resident resident resident resident to the committee, redirect the encourage the resident resi	rterly Minimum Data Set 3.0 lated 10-19-12 documented ief Interview for Mental hich indicated the resident d. active Medication Care Area ummary documented the egular diet, used a plate and curved utensils at meal ther level of feeding skills. If the resident was able to irred limited to extensive tivities of daily living (ADLs), inent of urine and use of ions would put the resident cal decline, appetite The CAA failed to address ms and behaviors related to esychotropic medications. Indicate the resident expendications and hallucinations) related hizoaffective disorder (a causes both a loss of sychosis) and mood in the floor, climbed on the floor when he/she ventions directed staff to the Behavior Management the resident when delusional,	F	272			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		175245	B. WIN	G		12/0	5/2012	
	ROVIDER OR SUPPLIER LIVINGCENTER - EDWA	RDSVILLE		7	EET ADDRESS, CITY, STATE, ZIP CODE 51 BLAKE ST. DWARDSVILLE, KS 66111			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 272	with a potential for all behavior at times rela schizoaffective disord pressured, and/or rar statements, repetitive terrible was going to distractibility, irritability anxiousness, change sad/pained/worried fa from activities and so Observation on 11-28 P.M. revealed the resliving area. On 11-29-12 at 9:29 administrative staff D lacked a comprehensive staff D lacked a comprehensive staff D lacked a comprehensive did not completed the mood MDS. The facility did not procare Area Assessment The facility failed to its symptoms/behaviors medications and faile comprehensive Care resident who received Resident #40's Quarter states and for the school of the	documented the resident eration in his/her mood and ted to his/her diagnosis of ler as evidenced by rapid, abling speech, negative fears/thinking something nappen, restlessness, y, repetitive health concerns, is in sleep patters, icial expressions, withdrawal cial interactions. 3-12 at approximately 2:00 ident sat in a chair in the A.M. during staff interview, acknowledged the CAA ive assessment of the comedications and stated ector wrote the CAAs for ions. A.M. Mental Health staff Of develop the CAA, but and behavior portion of the povide a policy regarding ints.	F	272				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	ULTIPLE LDING	CONSTRUCTION	(X3) DATE SU COMPLET	
		175245	B. WIN	IG		12/0	5/2012
	ROVIDER OR SUPPLIER	RDSVILLE	.	751	ET ADDRESS, CITY, STATE, ZIP CODE BLAKE ST. WARDSVILLE, KS 66111		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 272	with a Brief Interview (BIMS) of 15 which ir intact cognition. The antipsychotic and antipsychotic and antipsychotic medications and care for antipsychotic medications and care could lead to a declin cardiovascular complication and care could lead to address the could be addressed to addressed to a declinication and care could lead to addressed to addressed the could be addressed to a declinication and care could lead to addressed to addressed the could be addressed to a declinication and care could lead to addressed to addressed the could be addressed to a declinication and care care care care care care care care	of for Mental Status score adicated the resident with resident received ianxiety medications on 7 to the assessment. Sesment (CAA) dated 4/13/12 dications documented the at Lithium carbonate and the man to the resident was at risk dication side effects that the in physical functioning, ications and behaviors. The sest the resident's symptoms at to the resident's use of	F	272			
	medications related to anti-psychotic medications (Zyprexa Klonopin) dated 4/12. directed staff to moni report to physician are the anti-anxiety/hyproshould monitor for side antipsychotic medications and listed effects. The pharmac medication regimen reto complete an Abnord Scale (AIMS) quarter should invite the residence medications regimen reto complete an Abnord Scale (AIMS) quarter should invite the residence medications regimen reto complete an Abnord Scale (AIMS) quarter should invite the residence medications regimen reto complete an Abnord Scale (AIMS) quarter should invite the residence medications regimen reto complete an Abnord Scale (AIMS) quarter should invite the residence medications regimen reto complete an Abnord Scale (AIMS) quarter should invite the residence medications reto and ret	ated with use of psychotropic to anti-anxiety medication, ation, mood stabilizer at Lithium carbonate, 12 and revised 9/27/12 tor for side effects and ad listed the side effects for otic medications. Staff the effects of the tions and mood stabilizer					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION B	(X3) DATE SURVEY COMPLETED	
		175245	B. WIN	G		12/0	5/2012
	OVIDER OR SUPPLIER	RDSVILLE	•	7	EET ADDRESS, CITY, STATE, ZIP CODE 51 BLAKE ST. EDWARDSVILLE, KS 66111		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE A DEFICIENCY)		LD BE	(X5) COMPLETION DATE
F 279 SS=D	the resident walked droom to the dining room to the dining interview on 1 consultant staff O reprospect the Care Arout the mood and bethe The facility did not proceed the dining to the dining to the did symptoms/behaviors medications and failed comprehensive Care resident who received the develop, review and comprehensive plan of the facility must develop the facility must develop the did not proceed the did not proceed the did not proceed the did not proceed the facility failed to ideal the did not proceed the facility failed to ideal the did not proceed the facility failed to ideal the fa	/12 at 10:23 A.M. revealed own the hall from his/her om and sat down at a table. //29/12 at 9:36 A.M. reported the Mental Health e Care Area Assessments aviors. //29/12 at 11:15 A.M. orted he/she did not ea Assessments, but did fill navior portion of the MDS. // 20/12 at 11:15 A.M. orted he/she did not ea Assessments, but did fill navior portion of the MDS. // 20/12 at 11:15 A.M. orted he/she did not ea Assessments, but did fill navior portion of the MDS. // 20/12 at 11:15 A.M. orted he/she did not ea Assessments, but did fill navior portion of the MDS. // 20/12 at 11:15 A.M. orted he/she did not ea Assessments, but did fill navior portion of the MDS. // 20/12 at 11:15 A.M. orted he/she did not ea Assessments, but did fill navior portion of the MDS. // 20/12 at 11:15 A.M. orted he/she did not ea Assessments, but did fill navior portion of the MDS. // 20/12 at 11:15 A.M. orted he/she did not ea Assessments, but did fill navior portion of the MDS. // 20/12 at 11:15 A.M. orted he/she did not ea Assessments, but did fill navior portion of the MDS. // 20/12 at 11:15 A.M. orted he/she did not ea Assessments, but did fill navior portion of the MDS. // 20/12 at 11:15 A.M. orted he/she did not ea Assessments, but did fill navior portion of the MDS. // 20/12 at 11:15 A.M. orted he/she did not ea Assessments, but did fill navior portion of the MDS.		272			
	_	mental and psychosocial ed in the comprehensive					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		LE CONSTRUCTION	(X3) DATE SUF COMPLETI	
		175245	B. WIN	G		12/0	5/2012
	OVIDER OR SUPPLIER	ARDSVILLE	•	75	EET ADDRESS, CITY, STATE, ZIP CODE 51 BLAKE ST. DWARDSVILLE, KS 66111		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRODE	JLD BE	(X5) COMPLETION DATE
F 279	to be furnished to atthighest practicable psychosocial well-be §483.25; and any se be required under §4 due to the resident's §483.10, including the under §483.10(b)(4) This REQUIREMEN by: The facility identified The sample included observation, intervie facility failed to complan for 3 of 21 resident for 3 of 21 resident with a Brief score (BIMS) of 15, cognition. The resident with a Brief score (BIMS) of 15, cognition. The resident mobility, transfers, a bathing with no set until the Care Area Assed daily living (ADL) discompleted. The comprehensive 11/13/12 failed to add	describe the services that are tain or maintain the resident's physical, mental, and sing as required under revices that would otherwise 183.25 but are not provided exercise of rights under the right to refuse treatment. T is not met as evidenced as a census of 92 residents. If 21 residents, and record review the polete a comprehensive care lents sampled, (#74, #79, daily living. Barterly Minimum Data Set 2/12 documented the linterview for Mental Status which indicated intact ent required supervision with was independent with bed mbulation, dressing and up or physical help from staff. Essment (CAA) for activities of linot trigger and was not care plan last reviewed	F	279			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		PLE CONSTRUCTION	(X3) DATE SUF	
		175245	B. WIN	G		12/0	5/2012
	ROVIDER OR SUPPLIER	RDSVILLE		7	REET ADDRESS, CITY, STATE, ZIP CODE 51 BLAKE ST. EDWARDSVILLE, KS 66111	.2.0	<i></i>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	(X5) COMPLETION DATE	
F 279	resident was independe/she always prefer he/she showered or he/she showered or heeded with showers address shaving. Review of the resider staff documented on bath and lotion was a hair washed. Staff do not shaved. On 11/26 bath and staff did not shave the resident. Observation on 11/27 the resident stood at appropriately and unsuppropriately	care plan to address the ident with ADL's or that red a shower, how often now much assistance he/she is. The care plan did not int's bath sheets revealed 11/27/12 the resident had a applied, nails cleaned and cumented the resident was 6/12 the resident refused a document if they offered to interest in the state of the nurse's station dressed shaven in the shower and independently and then if let him/her into the shower independently and then if he/she needs anything er.	F	279			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		175245	B. WIN	G		12/05/2012	
	ROVIDER OR SUPPLIER	RDSVILLE	•	75	EET ADDRESS, CITY, STATE, ZIP CODE 51 BLAKE ST. DWARDSVILLE, KS 66111		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE				JLD BE	(X5) COMPLETION DATE	
F 279	whiskers then staff sh wanted to shave. Staresident very often be staff if he/she needed. The facility failed to complete ADL's formulated and problems, provide rol provide washcloths a grooming, monitor for complete ADL's having preference.	vanted. If the resident had hould ask his/her if he/she if did not approach the ecause he/she would ask if anything. omplete a comprehensive or this resident. Interly Minimum Data Set 2/12 documented the ervision with hygiene, eating is independent with toileting, independent with toileting, independent with depressive condition, mood disorder dications. The resident was vities of daily living. In vities of daily living (ADL) ost recent revision dated if the resident was at risk for erformance related to disorder and an abnormal initor for increased gait lier walker for ambulation, and towels for independent in assistance needed to encourage independent	F	279			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	[` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		175245	B. WING	₃		12/0!	5/2012
	OVIDER OR SUPPLIER	RDSVILLE		75	EET ADDRESS, CITY, STATE, ZIP CODE 1 BLAKE ST. DWARDSVILLE, KS 66111		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		_D BE	(X5) COMPLETION DATE
	entered the resident's would shave him/her agreed with the staff. Observation on 11/28 resident sat in the din unshaven. Observation on 11/29 resident sat in the din unshaven. Observation on 11/29 resident sat in the din was unshaven and his buring interview on 1 licensed nursing staff assist the resident with document when the reshower sheets. During interview on 1 administrative staff D then it should be care something specific for care plan for that issue were not care planned. During interview on 1 care staff K reported the assistance with show and undressing. The razor in his/her locked liked the regular shaves shaved the resident we razors daily. The residence is week, but the staff of the staff of the resident were showers a week, but the staff of th	sher bed unshaven. Staff froom and told him/her they on that day. The resident 1/12 at 4:44 P.M. the ing room and was 1/12 at 7:40 A.M. the ing room eating. He/She sher hair looked greasy. 1/28/12 at 4:16 P.M. Greported staff should the showers and shaving and esident shaved on the 1/29/12 at 9:36 A.M. reported if a CAA triggered planned. If there was a resident then staff should the Shaving and bathing d. 1/29/12 at 2:09 P.M. direct the resident required limited the sand help with dressing resident had an electric of drawer in his/her room, but the regular disposable dent usually accepted two did refuse at times.	F2	279			

A. BUILDING	(X3) DATE SURVEY COMPLETED	
175245 B. WING 12/	05/2012	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - EDWARDSVILLE STREET ADDRESS, CITY, STATE, ZIP CODE 751 BLAKE ST. EDWARDSVILLE, KS 66111		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 279 Continued From page 11 resident. - Resident #99's admission Minimum Data Set 3.0 Assessment (MDS) dated 9-26-12 documented the resident's Brief Interview for Mental Status Score (BIMS) of 15 which indicated the resident was alert and oriented. The resident required supervision with activities of daily living (ADLs) for dressing, eating, personal hygiene, and was independent with bed mobility, transfers, ambulation, toilet use, and bathing. The ADL Care Area Assessment (CAA) dated 10-10-12 documented the resident's memory was intact and his/her decision making cognitive skills were reasonable. The CAA documented per the nursing progress notes, the resident was independent with performing ADLs, and a decline in ADLs would result in a decreased self esteem and satisfaction, and place the resident trisk for skin breakdown and infection. Nursing would monitor and the resident's attending physician and psychiatrist would review as indicated. The record lacked evidence staff developed an		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	[` ′		LE CONSTRUCTION	(X3) DATE SUF	
			A. BUII	DING	<u> </u>		
		175245	B. WIN	G		12/0	5/2012
	OVIDER OR SUPPLIER	RDSVILLE		75	EET ADDRESS, CITY, STATE, ZIP CODE 51 BLAKE ST. DWARDSVILLE, KS 66111		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 280 SS=D	revealed the resident appeared greasy, an untrimmed nails. During staff interview direct care staff U staindependent with bat resident to make surfingernails needed clencourage the resident on the resident's ADL not on the CAA then staff care plan for the resident has the incompetent or other incapacitated under the participate in plannin changes in care and	s resident. 6-2012 at 11:18 A.M. t laid in bed and his/her hair d the resident had dirty, on 11-29-12 at 8:29 A.M. ated if a resident was hing, staff checked the e they were clean and if their eaned or trimmed, ent to let staff clean the nails. A.M. administrative staff D cord lacked a care plan for eeds and stated if it triggered if should have developed a dent. develop a comprehensive s resident. (k)(2) RIGHT TO INING CARE-REVISE CP right, unless adjudged wise found to be the laws of the State, to g care and treatment or treatment.		279			
	interdisciplinary team physician, a registere for the resident, and	e completion of the ssment; prepared by an and that includes the attending ed nurse with responsibility other appropriate staff in a lined by the resident's needs,					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		E CONSTRUCTION	(X3) DATE SU COMPLE	
		175245	B. WIN	G		12/0	05/2012
	ROVIDER OR SUPPLIER	ARDSVILLE	'	751	ET ADDRESS, CITY, STATE, ZIP CODE I BLAKE ST. IWARDSVILLE, KS 66111	, , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 280	the resident, the resident legal representative;	ne 13 acticable, the participation of ident's family or the resident's and periodically reviewed m of qualified persons after	F	280			
	by: The facility identified The sample included observation, intervie facility failed to revie address the resident	T is not met as evidenced d a census of 92 residents. d 21 residents. Based on w, and record review the w and revise the care plan to d's individual preferences for sidents reviewed for activities o. (#29)					
	Assessment (MDS) the resident's Brief In Score (BIMS) of 11, had moderately imparequired extensive a mobility, transfers, lod dressing, toileting, a required total assistation. The ADL Care Area documented the resilocomotion and required.	arterly Minimum Data Set 3.0 dated 10-5-12 documented nterview for Mental Status which indicated the resident aired decision making skills, ssistance of staff with bed comotion on and off the unit, and personal hygiene, and ance of staff with bathing. Assessment (CAA) summary dent used a wheelchair for iired extensive assistance of					
	personal hygiene an an order for active a	y, transfers, toileting, d bathing. The resident had ssistance for range of motion per and lower extremities.					

STATEMENT OF C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		PLE CONSTRUCTION	(X3) DATE SUF	
			A. BUI				
		175245	B. WIN	G		12/0	5/2012
	VIDER OR SUPPLIER VINGCENTER - EDWAI	RDSVILLE		7	EET ADDRESS, CITY, STATE, ZIP CODE 51 BLAKE ST. DWARDSVILLE, KS 66111		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	was at risk for skin intin physical function, do The 10-25-12 Care Playith a deficit in physical mobility impairment a Interventions directed resident to make chois and assist the resider was tired. The care president required externobility, transfers, dreshygiene, and bathing individualized intervent resident's bathing president's bathing president's preferent Care Sheet lacket the resident's preferent Care Sheet lacket the resident in his/her uncombed and looked On 11-26-12 at 12:49 he/she received his/h the afternoon and premorning. On 11-28-12 at 1:05 Festated staff gave residented their showers On 11-28-12 at 3:44 Fethe aides had sheets	ent's ADL decline, he/she degrity issues, further decline depression, pain and injury. Idan identified the resident cal function related to his/her and decreased ROM. It staff to encourage the aces with care as appropriate and with locomotion if he/she and documented the ansive assistance with bed dessing, toileting, personal and the ferences. In the care plan lacked antions related to the afterences. In the care Sheets and documentation regarding ances for bathing. In the resident stated are room and his/her hair was and greasy. In the resident stated are shower in the middle of afterred to shower early in the In the care staff J In the decline decline and decline and decreased to his/her the and documentation regarding and documentation re	F	280			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		PLE CONSTRUCTION	(X3) DATE SUF COMPLETI	
		175245	B. WIN	.G		12/0	5/2012
	ROVIDER OR SUPPLIER LIVINGCENTER - EDWAI	RDSVILLE		7	REET ADDRESS, CITY, STATE, ZIP CODE 51 BLAKE ST. EDWARDSVILLE, KS 66111		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 280	stated he/she typically preferences on the cashaving, and nail care. The 2006 facility provand Procedure documentation Guide of assistance the resiand any resident preference that the facility failed to replan to include the resibathing.	A.M. administrative staff D y did not put residents are plan regarding bathing, e. rided Bath, Shower Policy mented the Care Plan elines included the amount dent needed with bathing ferences.		280			
F 310 SS=D	UNAVOIDABLE Based on the compre resident, the facility mabilities in activities of unless circumstances condition demonstrate unavoidable. This incomplete to bathe, dress, and gambulate; toilet; eat; a or other functional control of the facility identified. The sample included observation, interview facility failed to provide	cludes the resident's ability	F	310			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		E CONSTRUCTION	(X3) DATE SUF COMPLET	
		175245	B. WIN	IG		12/0	5/2012
	ROVIDER OR SUPPLIER	RDSVILLE	1	75	EET ADDRESS, CITY, STATE, ZIP CODE 1 BLAKE ST. DWARDSVILLE, KS 66111	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 310	for ADL's. Findings included: Resident #74' quart (MDS) 3.0 dated 11/2 resident with a Brief I score (BIMS) of 15, w cognition. The resident hygiene and he/she w mobility, transfers, and bathing with no set up. The comprehensive of 11/13/12 did not addrest a shower or a bath. To living (ADL) care plant independent with ADI preferred a shower, hor how much assistant showers. The care plant independent with and lotion was a hair washed. Staff do not shaved. On 11/26 bath and staff did not offered to shave. Review of the resident staff documented on bath and the resident on 11/26/12 the r	erly Minimum Data Set /12 documented the nterview for Mental Status which indicated intact int required supervision with vas independent with bed inbulation, dressing and or physical help from staff. Fare plan last reviewed ess if the resident preferred here was no activity of daily to address the resident was and on the she always ow often he she showered ince he she needed with and did not address shaving. It's bath sheets revealed 11/27/12 the resident was /12 the resident refused a document if he she was It's bath sheets revealed 11/27/12 the resident had a pplied, nails cleaned and cumented the resident was /12 the resident refused a document if he/she was It's bath sheets revealed 11/27/12 the resident had a was not offered a shave. Itent refused a bath and no	F	310			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		ONSTRUCTION	(X3) DATE SU COMPLET	
		175245	B. WIN	3		12/0	05/2012
	OVIDER OR SUPPLIER	RDSVILLE		751 B	ADDRESS, CITY, STATE, ZIP CODE LAKE ST. ARDSVILLE, KS 66111		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 310	During interview on 1 care staff J reported is shower rather than a more often than the rwere scheduled. Staff and he/she showered staff checked to see throughout the shower throughout the shave when he/she will shave the staff shave the sh	shaven. 8/12 at 2:24 P.M. revealed II dressed and unshaven. 1/28/12 at 1:04 P.M. direct this resident preferred a tub bath and liked to shower egular 2 baths a week which if let him/her into the shower d independently and then if he/she needed anything er. 1/29/12 at 2:09 P.M. direct the resident had an electric art which he/she used to wanted. If the resident had nould ask his/her if he/she if did not approach the ecause he/she asked staff if ing. Provide assistance with ent.	F	310			
	documented the residual psychosis, psychotic	esment (CAA) dated 2/10/12 dent with depressive condition, mood disorder dications. The resident was					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1` ′		LE CONSTRUCTION	(X3) DATE SUF	
			A. BUII	DING			
		175245	B. WIN	G		12/0	5/2012
	ROVIDER OR SUPPLIER LIVINGCENTER - EDWA	RDSVILLE		75	EET ADDRESS, CITY, STATE, ZIP CODE 51 BLAKE ST. DWARDSVILLE, KS 66111		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 310	independent with activated 2/18/12 with m 11/16/12 documented decline in ADL self persychosis and mood gait. Staff should morproblems, provide rolprovide washcloths a grooming, monitor for complete ADL's and ADL's, bathing and preeded. The resident The care plan failed to shaving preference. Review of the resident document if staff offer the resident showere the resident bathed, It not shaved. The recoresident refusals to significant would shave him/her agreed with the staff. Observation on 11/28 resident sat in the dirunshaven. Observation on 11/28 resident sat in the dirunshaven.	vities of daily living (ADL) ost recent revision dated of the resident was at risk for erformance related to disorder and an abnormal nitor for increased gait ler walker for ambulation, and towels for independent reassistance needed to encourage independent provide assistance as addit dis/her own oral care, to address the resident's and the sharing of the sharing	F	3310			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		E CONSTRUCTION	(X3) DATE SUR\ COMPLETE	
		175245	B. WING	<u> </u>		12/0	5/2012
	OVIDER OR SUPPLIER	RDSVILLE		751	ET ADDRESS, CITY, STATE, ZIP CODE 1 BLAKE ST. WARDSVILLE, KS 66111		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 310	Continued From page		F 3	310			
	assist the resident with	1/28/12 at 4:16 P.M. G reported staff should th showers and shaving and esident shaved on the					
	care staff K reported assistance with show and undressing. The razor in his/her locked liked the regular shaved the resident with the resi	1/29/12 at 2:09 P.M. direct the resident required limited ers and help with dressing resident had an electric d drawer in his/her room, but ters which nursing had. Staff with the regular disposable dent usually accepted two did refuse at times.					
F 329 SS=D	shaving and cleaning	SIMEN IS FREE FROM	F 3	329			
	unnecessary drugs. A drug when used in ex duplicate therapy); or without adequate moi indications for its use						
	resident, the facility m who have not used at given these drugs und therapy is necessary	ensive assessment of a nust ensure that residents ntipsychotic drugs are not less antipsychotic drug to treat a specific condition cumented in the clinical					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE SUF	
			A. BUII	DING			
		175245	B. WIN	G		12/0	5/2012
	ROVIDER OR SUPPLIER LIVINGCENTER - EDWA	RDSVILLE		75	EET ADDRESS, CITY, STATE, ZIP CODE 51 BLAKE ST. DWARDSVILLE, KS 66111		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 329	drugs receive gradua behavioral intervention	who use antipsychotic I dose reductions, and	F	329			
	by: The facility identified The sample included observation, interview facility failed to docur	a census of 92 residents. 21 residents. Based on v, and record review the nent behavior monitoring for ions for 3 of 10 residents ions. (#64, #3, #40)					
	Assessment (MDS) d the resident with a Br	terly Minimum Data Set 3.0 lated 10-19-12 documented lief Interview for Mental hich indicated the resident d.					
	Assessment (CAA) so resident received a reguard, covered cups, times to maintain his/The CAA documente feed his/herself, requassistance with all ac was frequently incont psychotropic medicat	active Medication Care Area summary documented the egular diet, used a plate and curved utensils at meal her level of feeding skills. d the resident was able to ired limited to extensive tivities of daily living (ADLs), inent of urine and use of ions put the resident at risk line, appetite changes, and					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIP	LE CONSTRUCTION	(X3) DATE SUF	
			A. BUII	DING			
		175245	B. WIN	G		12/0	5/2012
	OVIDER OR SUPPLIER	RDSVILLE		7!	EET ADDRESS, CITY, STATE, ZIP CODE 51 BLAKE ST. DWARDSVILLE, KS 66111		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 329	with a potential for ps (paranoia, delusions, to the diagnosis of somental condition that contact with reality (p problems) and laid or furniture, and crawled was psychotic. Interverefer the resident to the Committee, redirect the encourage the reside concerns, and removisituation. The 8-3-12 care plan with a potential for all behavior at times relaschizoaffective disorce pressured, and/or ran statements, repetitive terrible was going to distractibility, irritability anxiousness, change sad/pained/worried farom activities and so Record review of the Order Sheet (POS) dordered staff to give the anti-depressant medical daily beginning 10-20 anti-psychotic medical 2-9-11, Zyprexa (an abeginning 8-22-12, Zyprexa)	documented the resident ychotic symptoms and hallucinations) related hizoaffective disorder (a causes both a loss of sychosis) and mood in the floor, climbed on it on the floor when he/she rentions directed staff to the Behavior Management the resident when delusional, and to express his/her is the resident from a trigger documented the resident reation in his/her mood and sted to his/her diagnosis of the as evidenced by rapid, anbling speech, negative infears/thinking something the patterns, as in sleep patterns, as in sleep patterns, acial expressions, withdrawal cial interactions. November 2012 Physician's ocumented the physician the resident Lexapro (and cation) 20 milligrams (mg)	F	329			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION	(X3) DATE SUF	
		175245	B. WIN	G	 	12/0	5/2012
	ROVIDER OR SUPPLIER	RDSVILLE		7	REET ADDRESS, CITY, STATE, ZIP CODE 51 BLAKE ST. CDWARDSVILLE, KS 66111	.2.0	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 329	The September 2012 Sheet documented the and Zyprexa Zydis for Staff monitored the redepression, withdraw Flow Sheet lacked documented to the Cotober 2012 Belacked medications the Institute of the Cotober 2012 Belacked medications the Institute of Institute of the Institute of the Institute of the Institute of Institute of the Institute of the Institute of the Institute of Institute of the Institute of Institu	n (an anti-anxiety ce daily beginning 6-19-11. Behavior Monthly Flow the resident received Lexapro or Schizoaffective disorder. Sesident for anxiety, and, and false beliefs. The pocumentation the resident or Clonazepam. Chavior Monthly Flow Sheet the resident received for ff monitored that included withdrawal and false beliefs. Behavior Monthly Flow the resident received Lexapro that in the resident received and Clonazepam. The Flow aff monitored the resident ton, withdrawal and false 3-12 at approximately 2:00 sident sat in a chair in the resident the resident sat in a chair in the resident the resident sat in a chair in the resident the resident sat in a chair in the	F	329			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SU COMPLET	
		175245	B. WING _		12/0	5/2012
	OVIDER OR SUPPLIER	RDSVILLE		REET ADDRESS, CITY, STATE, ZIP CODE 751 BLAKE ST. EDWARDSVILLE, KS 66111		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 329	listed with the behaviorantipsychotic medical. The facility failed to domonitoring for psychological resident.	d the medications were not or for the Depakote or other tions on the sheet. ocument behavior otropic medications for this	F 32	9		
	(MDS) 3.0 dated 8/18 resident with a Brief I Score of 14, which in intact cognition. The I and delusions and to antianxiety medicatio days prior to the asset	nterview for Mental Status dicated the resident with resident had hallucintations ok antipsychotic and ns on 7 days during the 7 essment.				
	11/28/11 documented showers but staff con and he/she required a shower. The Care Area Assess medications dated 11 resident with diagnos disorder, history of ra depressive disorder, esophageal reflux, exabnormal movement. The resident was able	exinced him/her to shower daily redirection by staff to ssment for psychotropic /28/11 documented the				

STATEMENT OF DEFICIE AND PLAN OF CORRECT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION		X3) DATE SURVEY COMPLETED	
		175245	B. WIN	IG		12/0	5/2012	
NAME OF PROVIDER OF		RDSVILLE		7	REET ADDRESS, CITY, STATE, ZIP CODE 51 BLAKE ST. EDWARDSVILLE, KS 66111			
	EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
personal had epi mostly of hallucin at times respond medical Risperd at risk for related. The car depress 8/30/12 moods/ Care Tr The car use of L Clonaze and Top side effor side efform the cord document behavior includer yelling a delusion and end and not significal.	sodes of refusions and beas. The resident ded to the voice tions consisted tal, Enalapril, I dal consta and for falls, side eat to the medical re plan for schistive disorder ded tions and for falls, side eat to the medical re plan for schistive disorder ded tions and racker. The plan dated for the plan dated for the resident the resident staff, usually nal thinking. Succurage the retify the physiciant changes.	bathing activities. He/She sing meals. He/She slept and had delusions and lieved he/she was pregnant a seemed to hear voices and ses. The resident's current d of Fluphenazine, Lexapro, Clonazepam, Topamaz. The resident was ffects and adverse effects	F	329				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SUF COMPLET	
	175245	B. WING		12/0	5/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - EDWARI	DSVILLE	S	STREET ADDRESS, CITY, STATE, ZIP CODE 751 BLAKE ST. EDWARDSVILLE, KS 66111		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
for schizophrenia (a cobegining 12/15/09, Closeizures and panic disconstruction for schizophrenia beging (a medication for mood 500 mg every day for cobe 8/24/11, Fluphenazine disorders and schizophhours as needed for schizophrenia begining. The Behavior Monthly 10/2012 revealed staff did not have depression hallucinations and was compulsive. Staff did nowere being given for the November 2012 Behave agitation, anxiety, comparise beliefs and halluced delusions listed Effector used for those target bothe other psychotropic and failed to document the Risperdal consta, Cobervation on 11/27/20 the resident sat in the coforward in the chair with face. During interview on 11/21/21/20 the resident sat in the coforward in the chair with face.	perdal consta 50 mg every 14 days at bed time ognitive/behavior disorder) onazepam (a medication for orders) 2 mg every 8 hours ning 9/16/10, Depakote ER d disorders and siezures) depression begining (a medication for psychotic hrenia) 10 mg every 6 chizophrenia since al 4 mg twice daily for g 2/24/10. Flow Sheet for 9/2012 and d documented the resident on, false beliefs, a not agitated, anxious or not list what medications he behaviors. The evior Monitoring Sheet for hypulsiveness, depression, cinations, paranoia and or as the medication being hehaviors. Staff failed to list medications on this sheet t behavior monitoring for Clonazepam, Depakote, herdal. 12 at 4:28 P.M. revealed dining room leaning th his/her hands over their	F 32	29		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SUF COMPLET	
		175245	B. WIN	G		12/0	5/2012
	ROVIDER OR SUPPLIER	RDSVILLE	•	75	EET ADDRESS, CITY, STATE, ZIP CODE 51 BLAKE ST. DWARDSVILLE, KS 66111		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 329	He/She acknowledge listed with the behavior antipsychotic medications were effect to buring interview on 1 care staff K reported himself/ herself and the about him/her. The resident for psychotresident. - Resident #40's Quark (MDS) 3.0 dated 9/7/ with a Brief Interview (BIMS) of 15 which in intact cognition. The rantipsychotic and antipsychotic and antipsychotic and antipsychotic medications and care for antipsychotic medications associated in the care plan for pote complications associated in the property of the care plan for pote complications associated in the property of the care plan for pote complications associated in the property of the planting in the property of the planting in the plant	d the medications were not or for the risperdol or other tions on the sheet, but if the any behaviors then the ective. 1/29/12 at 2:09 P.M. direct the resident talked to hought people were talking esident also yelled out. ocument behavior etropic medications for this arterly Minimum Data Set 12 documented the resident of Mental Status score dicated the resident with resident received ianxiety medications on 7 rior to the assessment. ssment (CAA) dated 4/13/12 ications documented the any Lithium carbonate and the was compliant with s. The resident was at risk ication side effects that the in physical functioning, ications and behaviors.	F	329			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		STRUCTION	(X3) DATE SUF COMPLET	
		175245	B. WINC	S		12/0	5/2012
	ROVIDER OR SUPPLIER LIVINGCENTER - EDWAI	RDSVILLE		751 BLA	DRESS, CITY, STATE, ZIP CODE KE ST. DSVILLE, KS 66111		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 329	directed staff to monit report to physician and the anti-anxiety/hypnoshould monitor for side antipsychotic medications and lister effects. The pharmac medication regimen reto complete an Abnor Scale (AIMS) quarter should invite the resident 1:1 conversation to do The Physician Order ordered staff to give the milligrams (mg) at beed begining 7/15/9, lithiu P.M. for paranoid schand Klonopin 0.5 mg schizophrenia begining The Behavior Monthly 2012 and October 20 documented the reside depression, false belications false belications they more and medications were sheet. Observation on 11/27 the resident walked definitions for side of the staff to monitor the properties of the staff to medications were sheet.	in, Lithium carbonate, 12 and revised 9/27/12 for for side effects and ad listed the side effects for otic medications. Staff le effects of the tions and mood stabilizer and those possible side by was to do monthly eviews. Staff were directed and Involuntary Movement ly and as needed. Staff lent to activities and provide ecrease target behaviors. Sheet dated 11/6/12 the resident Zyprexa 20 do time for schizophrenia and carbonate 300 mg at 4:00 tizophrenia begining 5/10/12 twice a day for 12 revealed staff lent had no anxiety, effs, ia/delusions or do not indicate what the intored for those behaviors are not listed on the behavior of 12 at 10:23 A.M. revealed own the hall from his/her own and sat down at a table.	F3	329			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION	COMPLET	
		175245	B. WIN	IG		12/0	5/2012
	OVIDER OR SUPPLIER	RDSVILLE	'	75	REET ADDRESS, CITY, STATE, ZIP CODE 51 BLAKE ST. EDWARDSVILLE, KS 66111		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 329	licensed nursing staff behaviors on the Beh the Medication Admir He/She acknowledge listed with the behavior antipsychotic medica not have any behavior were effective. The facility failed to make the resident with psychotic medical to the resident with psychotic medical to the facility failed to make the fac	G reported staff document avior Monitoring sheets in histration Record (MAR). d the medications were not for the resident's tions, but if the resident did are then the medications		329 428			
SS=D	The drug regimen of reviewed at least one pharmacist. The pharmacist must the attending physicial			720			
	by: The facility identified The sample included observation, interview facility failed to docur	a census of 92 residents. 21 residents. Based on 0, and record review the nent behavior monitoring for ions for 3 of 10 residents ons. (#64, #3, #40)					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SUF	
		175245	B. WIN	G		12/0	5/2012
	OVIDER OR SUPPLIER	RDSVILLE		75	EET ADDRESS, CITY, STATE, ZIP CODE 51 BLAKE ST. DWARDSVILLE, KS 66111	, .2.0	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 428	Assessment (MDS) of the resident with a B Status score of 15, we was alert and oriented. The 2-11-12 Psychological	rterly Minimum Data Set 3.0 dated 10-19-12 documented rief Interview for Mental which indicated the resident ed. active Medication Care Area nummary documented the egular diet, used a plate, and curved utensils at meal where level of feeding skills. Ed the resident was able to sired limited to extensive civities of daily living (ADLs), tinent of urine and use of tions put the resident at risk eline, appetite changes, and	F	428			
	Committee, redirect to encourage the reside concerns, and remove situation. The 8-3-12 care plan with a potential for all	the resident when delusional, ent to express his/her returned the resident from a trigger documented the resident teration in his/her mood and ated to his/her diagnosis of					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SUF COMPLET	
		175245	B. WIN	G		12/0	5/2012
	OVIDER OR SUPPLIER	RDSVILLE	·	7	EET ADDRESS, CITY, STATE, ZIP CODE 51 BLAKE ST. DWARDSVILLE, KS 66111		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRODERICATION OF THE APPRODERICATION OF THE APPRODERICATION OF THE APPRODERICATION OF THE APPROPRIES OF THE AP	JLD BE	(X5) COMPLETION DATE
F 428	pressured, and/or ran statements, repetitive terrible was going to I distractibility, irritability anxiousness, change sad/pained/worried far from activities and so Record review of the Order Sheet (POS) dordered staff to give the anti-depressant medically beginning 10-20 anti-psychotic medically beginning 8-22-12, Zyneeded for schizoaffe 6-11-11, Clonazepart medication) 1 mg twice The September 2012 Sheet documented the and Zyprexa Zydis fo Staff monitored the redepression, withdraw Flow Sheet lacked documented the schizoaffe or the October 2012 Belacked medications the his/her behaviors staff anxiety, depression, with the November 2012 Sheet documented the and lacked documented the a	ler as evidenced by rapid, inbling speech, negative fears/thinking something nappen, restlessness, y, repetitive health concerns, is in sleep patterns, incial expressions, withdrawal interactions. November 2012 Physician's ocumented the physician he resident Lexapro (and cation) 20 milligrams (mg) (mg) (mg) (mg) (mg) (mg) (mg) (mg)	F	428			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION G	(X3) DATE SUF	
		175245	B. WIN	G		12/0	5/2012
	OVIDER OR SUPPLIER	RDSVILLE		7	REET ADDRESS, CITY, STATE, ZIP CODE 51 BLAKE ST. EDWARDSVILLE, KS 66111		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 428	for anxiety, depression beliefs. Observation on 11-28 P.M. revealed the resiliving area. During staff interview direct care staff Q state of each residents behaviors to the nurse behaviors to the nurse licensed nurse G reposite behaviors on the behaviors of the monthly Reviews from Januar revealed no suggestic behaviors related to the psychotropic medicate. During an interview of Consultant staff P reposite facility could monispecific to individual pand acknowledged the	aff monitored the resident in, withdrawal and false -12 at approximately 2:00 ident sat in a chair in the on 11-28-12 at 2:51 P.M. Ited they were made aware aviors on the Care Sheet estaff and reported any identifications. on 11-28-12 at 4:16 P.M. Iteration of the Depakote or other instration record (MAR). If the medications were not for the Depakote or other inso on the sheet. If Pharmacy Regimen is a continuous of the need to monitor the resident's individual ons. In 11-29-12 at 4:30 P.M. Iterations or the sheet was unsure if the tor resident behaviors in the selections of the medications is especially and the resident in t	F	428			
	_	ltant failed to recognize and e irregularity that the facility					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		ELE CONSTRUCTION		(3) DATE SURVEY COMPLETED	
		175245	B. WIN	G		12/0	5/2012	
	OVIDER OR SUPPLIER	RDSVILLE		7	EET ADDRESS, CITY, STATE, ZIP CODE 51 BLAKE ST. DWARDSVILLE, KS 66111			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 428		e 32 onitor the efficacy of the ions residents received.	F	428				
	(MDS) 3.0 dated 8/18 resident with a Brief II Score of 14, which indintact cognition. The rand delusions and to antianxiety medication days prior to the asset	nterview for Mental Status dicated the resident with resident had hallucintations bk antipsychotic and ns on 7 days during the 7 ssment. sment for behaviors dated						
	showers but staff con	vinced him/her to shower daily redirection by staff to						
	medications dated 11 resident with diagnos disorder, history of ra depressive disorder, lesophageal reflux, ex abnormal movement. The resident was able needs to staff. He/She personal hygiene and had episodes of refus mostly during the day hallucinations and be at times. The resident responded to the voic medications consisted.	sh and other skin eruption, nistory of pain, hypertension, trapyramidal disease, disorder and hypothroidism. to communicate his/her to refused to participate in bathing activities. He/She sing meals. He/She slept and had delusions and lieved he/she was pregnant to seemed to hear voices and ties. The resident's current						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SUF COMPLET	
		175245	B. WIN	IG		12/0	5/2012
	ROVIDER OR SUPPLIER	RDSVILLE	•	7	REET ADDRESS, CITY, STATE, ZIP CODE 51 BLAKE ST. EDWARDSVILLE, KS 66111		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 428	at risk for falls, side e related to the medica The care plan for sch depressive disorder of 8/30/12 directed staff mood/behavior and tr Care Tracker. The care plan dated use of lexapro, hypnomolecular classical effects of those is side effects. The comprehensive of documented the residular effects. The comprehensive of those is side effects.	Topamaz. The resident was ffects and adverse effects tions. izoaffective disorder and lated 11/28/11 last revised to observe the resident's ack them using the Kiosk 11/28/11 for antidepressant with the late of Ambien and	F	428			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		LE CONSTRUCTION	(X3) DATE SUF COMPLET	
			A. BUII	.DING			
		175245	B. WIN	G		12/0	5/2012
	ROVIDER OR SUPPLIER LIVINGCENTER - EDWA	RDSVILLE		75	EET ADDRESS, CITY, STATE, ZIP CODE 61 BLAKE ST. DWARDSVILLE, KS 66111		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 428	for psychotic disorder every 6 hours as nee schizophrenia12/15/0 daily for schizophreni The Behavior Monthly 10/2012 revealed stadid not have depress hallucinations and was compulsive. Staff did were being given for November 2012 Behaagitation, anxiety, corfalse beliefs and halludelusions listed Effex used for those target the other psychotropi and failed to docume the Risperdal consta, Fluphenazine and Ris Reviews for the past 11/23/12 revealed no monitor behaviors relindividual psychotropi Observation on 11/27 the resident sat in the forward in the chair was face. During interview on 1 licensed nursing staff behaviors on the Behathe Medication Admir	uphenazine (a medication rs and schizophrenia) 10 mg ded for 19 and Risperdal 4 mg twice a beginning 2/24/10. If Flow Sheet for 9/2012 and ff documented the resident ion, false beliefs, as not agitated, anxious or not list what medications the behaviors. The avior Monitoring Sheet for mpulsiveness, depression, ucinations, paranoia and or as the medication being behaviors. Staff failed to list c medications on this sheet int behavior monitoring for Clonazepam, Depakote, sperdal. If Pharmacy Regimen year with last review on a suggestion of the need to ated to the resident's ic medications. If 12 at 4:28 P.M. revealed a dining room leaning with his/her hands over their	F	428			

DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′			(X3) DATE SUF COMPLETI	
	175245	B. WIN	IG		12/0	5/2012
OVIDER OR SUPPLIER	RDSVILLE	•	7	51 BLAKE ST.		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOU	LD BE	(X5) COMPLETION DATE
listed with the behavior antipsychotic medicate resident did not have medications were effect to buring interview on 1 care staff K reported thimself/ herself and the about him/her. The resident staff P reported to individual pand in a psychiatric sclee-way for behavior of the Pharmacy Consultant staff P reported to individual pand in a psychiatric sclee-way for behavior of the Pharmacy Consultant report to the facility failed to effect these psychoactive medication. The resident medications and care staff provided the provided that the provided resident took Zyprexak Klonopin. The resider medications and care	or for the risperdol or other ions on the sheet, but if the any behaviors then the ective. 1/29/12 at 2:09 P.M. direct the resident talked to hought people were talking sident also yelled out. 1/29/12 at 3:30 P.M. orted he/she was unsure if itor resident behaviors beychotropic medications etting there could be a lot of monitoring. Illant P failed to recognize ity, the irregularity that the vely monitor the efficacy of hedications. Interly Minimum Data Set 1/2 documented the resident for Mental Status score dicated the resident with resident received ianxiety medications on 7 froir to the assessment. Issment (CAA) dated 4/13/12 ications documented the in, Lithium carbonate and it was compliant with s. The resident was at risk	F	428			
could lead to a declin	e in physical functioning,					
	CONIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From page listed with the behavior antipsychotic medicate resident did not have medications were effet During interview on 1 care staff K reported to himself/ herself and the about him/her. The resident did not in a psychiatric so lee-way for behavior in The Pharmacy Consuland report to the facility failed to effective these psychoactive medicative medications. The resident #40's Qual (MDS) 3.0 dated 9/7/ with a Brief Interview (BIMS) of 15 which in intact cognition. The resident gray for the 7 days processed for antipsychotic and antipsychotic medications and care for antipsychotic medications	CORRECTION IDENTIFICATION NUMBER:	OVIDER OR SUPPLIER LIVINGCENTER - EDWARDSVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 35 listed with the behavior for the risperdol or other antipsychotic medications on the sheet, but if the resident did not have any behaviors then the medications were effective. During interview on 11/29/12 at 2:09 P.M. direct care staff K reported the resident talked to himself/ herself and thought people were talking about him/her. The resident also yelled out. During interview on 11/29/12 at 3:30 P.M. consultant staff P reported he/she was unsure if the facility could monitor resident behaviors specific to individual psychotropic medications and in a psychiatric setting there could be a lot of lee-way for behavior monitoring. The Pharmacy Consultant P failed to recognize and report to the facility, the irregularity that the facility failed to effectively monitor the efficacy of these psychoactive medications. - Resident #40's Quarterly Minimum Data Set (MDS) 3.0 dated 97/12 documented the resident with a Brief Interview for Mental Status score (BIMS) of 15 which indicated the resident with intact cognition. The resident received antipsychotic and antianxiety medications on 7 days for the 7 days prior to the assessment. The Care Area Assessment (CAA) dated 4/13/12 for antipsychotic medications documented the resident took Zyprexa, Lithium carbonate and Klonopin. The resident was compliant with medications and cares. The resident was at risk for antipsychotic medication side effects that	OVIDER OR SUPPLIER LIVINGCENTER - EDWARDSVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 35 listed with the behavior for the risperdol or other antipsychotic medications on the sheet, but if the resident did not have any behaviors then the medications were effective. During interview on 11/29/12 at 2:09 P.M. direct care staff K reported the resident talked to himself/ herself and thought people were talking about him/her. The resident also yelled out. During interview on 11/29/12 at 3:30 P.M. consultant staff P reported he/she was unsure if the facility could monitor resident behaviors specific to individual psychotropic medications and in a psychiatric setting there could be a lot of lee-way for behavior monitoring. The Pharmacy Consultant P failed to recognize and report to the facility, the irregularity that the facility failed to effectively monitor the efficacy of these psychoactive medications. - Resident #40's Quarterly Minimum Data Set (MDS) 3.0 dated 9/7/12 documented the resident with a Brief Interview for Mental Status score (BIMS) of 15 which indicated the resident with intact cognition. The resident received antipsychotic and antianxiety medications on 7 days for the 7 days prior to the assessment. The Care Area Assessment (CAA) dated 4/13/12 for antipsychotic medications documented the resident took Zyprexa, Lithium carbonate and Klonopin. The resident was compliant with medications and cares. The resident was at risk for antipsychotic medication side effects that	CONTRECTION IDENTIFICATION NUMBER: A BUILDING B. WING	OVIDER OR SUPPLIER 175245 STREET ADDRESS, CITY, STATE, ZIP CODE 751 BLAKE ST. EDWARDSVILLE, KS 66111 SUMMARY STATEMENT OF DEFICIENCIES GLOAD DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 35 Issted with the behavior for the risperdol or other antipsychotic medications on the sheet, but if the resident did not have any behaviors then the medications were effective. During interview on 11/29/12 at 2:09 P.M. direct care staff K reported the resident talked to himself/ herself and thought people were talking about him/her. The resident also yelled out. During interview on 11/29/12 at 3:30 P.M. consultant staff P reported he/she was unsure if the facility could monitor resident behaviors specific to individual psychotropic medications and in a psychiatric setting there could be a lot of lee-way for behavior monitoring. The Pharmacy Consultant P failed to recognize and report to the facility, the irregularity that the facility fould be effectively monitor the efficacy of these psychoactive medications. - Resident #40's Quarterly Minimum Data Set (MDS) 3.0 dated 97/1/2 documented the resident with a Biref Interview for Mental Status score (BIMS) of 15 which indicated the resident with intact cognition. The resident received antipsychotic and antianxiety medications on 7 days for the 7 days prior to the assessment. The Care Area Assessment (CAA) dated 4/13/12 for antipsychotic medications documented the resident took Zyprexa, Lithium carbonate and Klonopin. The resident was compliant with medications and cares. The resident was at risk for antipsychotic medications side effects that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		175245	B. WIN	G	 	12/0	5/2012	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - EDWARDSVILLE				7	EEET ADDRESS, CITY, STATE, ZIP CODE 51 BLAKE ST. EDWARDSVILLE, KS 66111	, .2.0		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		(EACH CORRECTIVE ACTION SHOU	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (COMP D/		
F 428	,		F	428				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
		175245	B. WING	i	12/0	5/2012	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - EDWARDSVILLE				STREET ADDRESS, CITY, STATE, ZIP COD 751 BLAKE ST. EDWARDSVILLE, KS 66111	E		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION		SHOULD BE COMPLETION	
F 428	Review of the monthly Review for the past yr 10/17/12 revealed not the facility to monitor resident's individual procession on 11/27 the resident walked droom to the dining room to the dining staff behaviors on the Behaviors on the Behaviors on the Behaviors on the behavior antipsychotic medicate and the procession of the dining interview on 1 consultant staff P repute facility could monispecific to individual pand in a psychiatric seleeway for behavior in The Pharmacy Consultant report to the facility	y Pharmacy Regimen ear with last review on o suggestion of the need for behaviors related to the esychotropic medications. 7/12 at 10:23 A.M. revealed own the hall from his/her om and sat down at a table. 1/28/12 at 4:16 P.M. G reported staff document avior Monitoring sheets in histration Record (MAR). d the medications were not or for the resident's tions, but if the resident did ors then the medications 1/29/12 at 3:30 P.M. orted he/she was unsure if itor resident behaviors beychotropic medications etting there could be a lot of monitoring. ultant P failed to recognize ity, the irregularity that the ively monitor the efficacy of	F 4	DEFICIENC			